FINAL REPORT

Key Informant Interviews on Health Care Access & Insurance in Montana

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Executive Summary

Key Informant Interviews formed one part of a three-part research component on the Montanan State Planning Grant on the Uninsured. The other two were the telephone surveys of households and businesses and the four focus groups held in both western and eastern Montana. The goal of the key informant interviews was to include input from those health care professionals, agency personnel, advocates and providers with unique knowledge about the problem of people going without health insurance in the state. The thirty individuals chosen to be interviewed had specialized insights and understanding around either certain populations or market sectors in Montana that are impacted when people go without health insurance. The result is an interesting mix of seemingly disconnected pieces that ultimately represent a snapshot of the current situation in Montana. The pieces do not come together into a coherent whole, rather they remain segmented knowledge and approaches depending on the interviewees vantage point.

Despite this apparent disconnect, there were three main themes that arose:

- cost is the single reason identified by all interviewees as the reason that people do not have health insurance;
- the system as it exists today is broken and can not be fixed; and
- ultimately, the only way to replace the current system is with some type of universal, single-payer approach.

A picture emerged of an impending crisis in the private sector of much greater magnitude than in the public sector. The spiraling costs of health care and health insurance is creating a untenable situation for many full-time working families who do not get offered health insurance through their jobs. The expectation of benefits through work is no longer a reality and more individuals are trying to find an affordable plan on the open market. As they discover the cost, complexity and lack of products, they are having to make harsh choices about whether to risk not carrying insurance while hoping they do not get sick, finding a job with benefits or paying exorbitant prices for limited coverage.

On the whole most interviewees were ambivalent about expanding public health insurance programs primarily because it is just not realistic to think this might happen. The current state economy just would not allow expansion and most just wanted to see a halt to further cuts to these programs. The Children's Health Insurance Program (CHIP) was universally praised for its relative ease of access and for its focus on children's well-being. It was also the most identified program in need of expansion.

A strong sense of compassion for and empathy with those struggling with health insurance problems came through during every interview. There was also a sense of injustice that people, often in the middle of an acute or critical health event or without any previous experience, had to wade through the rules and regulations of the tangled web of health insurance. This says much for the Montanan individuals who are committed to serving people in some health care capacity.

Key Informant Interviews on Health Care Access & Insurance in Montana State Planning Grant

Introduction

Thirty interviews were conducted between March and July 2003. These interviews represent seven from the health provider community, seven from community-based organizations or community leaders, eight from private industry and eight representing administrators of public agencies or non-governmental organizations. A concerted effort was made to interview representatives from the farming and ranching sector and from those working with populations traditionally without health insurance. This goal was met which resulted in an even distribution of interviews being completed in the market sectors originally identified. The Grant Director, the Administrator of the Health Policy and Services Division of DPHHS and the interviewer, selected interviewees. They were chosen because they bought unique, in-depth knowledge to the problems related to lack of access to health insurance and could be relied upon to understand the complexities within their piece of the issue. This was certainly the case in all instances and the interviews provided excellent insights into different aspects of the health insurance crisis.

Questionnaires (Appendix A) were developed for each different sector interviewed with input from questionnaires used in other states with similar planning grants. However, they were remodeled to fit the unique characteristics of Montana. But it is important to emphasize that the questions were used in an open-ended format and as a way to introduce certain important topics rather than in a survey research type of format. This allowed the interviewees to introduce ideas and insights that reflected their own knowledge and perspective.

The themes and topics discussed below reflect the conversations with the interviewees. It is quite likely that someone with in-depth knowledge from one sector can point out errors in technicalities or comments made by someone in another sector. It is important that these disparities are in this report as it underlies the misinformation, misconceptions and misunderstandings people, even the experts, have about health insurance. No one sector has a corner on all the knowledge.

It is also important to note that the interviews were conducted with the understanding of absolute confidentiality. All interviewees signed an Informed Consent Form (Appendix B). Necessary measures have been taken to ensure that no one can be identified in this report and notes from the interviews have been destroyed and transcripts have been deleted from the active computer files and transferred to a secured disk.

I. Major Themes

The three following themes were consistent across all interviews:

- all respondents identified cost as the reason that people do not have health insurance or that businesses cannot offer it as a benefit;
- that the current system(s) can not be fixed; and
- most respondents, who addressed long-term solutions, identified some type of universal single-payer health system.

Despite the three consistent ideas there seems to be a disconnect from the larger, more coherent approach needed for a systemic level solution. Only a few interviewees saw the problem from a big enough picture to avoid identifying other sectors as being the cause of the problem. Although even those coming from a traditionally non-business perspective or those who might not have knowledge about the private sector all agreed that businesses are more and more being forced to drop good health plans because of what it costs them. There continued to be a frustration about what to do about the complexities of funding mechanisms, although many would like to see the expansion of current programs.

II. Other Major Themes and Contributing Issues

Tiered Health Care System

The issue of the current system of health care being a tiered system was often mentioned, with many interviewees being worried that this will only get worse. They felt it comes from the development of piecemeal, categorical public insurance programs for those accessing health insurance through the government. More problematic is the development of a "haves" and "have nots" system within the private sector as businesses, of all sizes, re-think what benefits they can or cannot afford to offer. There is no doubt in most interviewees' minds that any solution must address the continuing development of a primary, secondary and tertiary health care system; primary for those with good health insurance who can afford the best, secondary for those with limited health insurance in the private sector and those who have categorical coverage through the public sector and tertiary for those with no insurance. It is very interesting to note that the later category includes those who work but are not offered health insurance and who cannot afford to buy it as an individual as well as those on the very bottom of the economic ladder who do not access public programs for whatever reason.

Along with a tiered system many people pointed to the segmentation of the health care system that has occurred as more and more categorical programs are created. The system as it currently exists is piecemeal leaving health care consumers scratching their heads to figure it out. Those that have had to understand the system because of their jobs are familiar with it and can understand the acronyms and lingo – those outside this "in-the-know" circle are operating in a swirling mess.

Societal Choices

The concept of rationing health care was often mentioned and that we as a society have to make some of those hard choices so that the escalation in costs can somehow be contained. Most interviewees who talked about these hard choices were not

hopeful that they would be made which indicated that in their minds any drastic systemic change to the health care system would not be forthcoming. If these hard decisions about rationing health care are not made, then society must accept the cost of providing health care on a scale that many Americans have come to expect. Some felt that health care as a basic right should be, but is not, part of the debate. Both ends of the extreme, severely rationing health care or universal health care, were often brought up in the same interview reflecting the ambivalence that exists in the country as a whole on the subject. It is interesting that, although they had no concrete plan as to how to solve the health care problem, several interviewees had faith in America's ability to come up with an answer.

Pre-Existing Conditions & Large Deductibles

Many interviewees particularly mentioned the problem people have with pre-existing conditions or large deductibles. Often the situation with large deductibles meant that in effect they had no plan, and due to cost they have to postpone going to the doctor until they had no choice and often ended up in the emergency room. Several people with pre-existing conditions were interviewed and they were not only locked into staying on one plan but were totally at the mercy of paying whatever that plan cost which sometimes translated into double digit cost increases. Five thousand dollar deductibles were not unusual either for the interviewees themselves or for people they knew.

Montana Economy

Montana's economy played a backdrop to people's responses but was not identified as "the" problem; most interviewees saw the problems around health insurance as larger than just this state or any one state. Often they underlined that solutions could not come from state governments but would have to come from the federal level. Those who deal with people who use public programs to access their health insurance mentioned the Montana economy most. Their comments reflected their fear that a further downturn in the economy would result in an increased use of their services while the state would be further cutting expenditures as state revenues fell. The reality of an overall bad economy led some people to be pessimistic about a solution being possible at any level.

Underinsured & Catastrophic Plans

There was not a representative answer to how people defined "underinsured", in fact, the answers were very diverse and often indicated the interviewees' professional situation or ideological viewpoint. It is interesting to note that 19 interviewees thought having a catastrophic plan was being underinsured, but only 3 thought that a catastrophic plan constituted a minimum "bare bones" insurance policy. Indeed the whole issue of catastrophic policies was frequently mentioned by all interviewees with often-derogatory remarks whether they had to deal with the issue on a personal or professional level. One owner of a private company said he was "embarrassed" that all he could offer was a catastrophic plan – even though it covered his family also.

III. Private Sector

The issue of health insurance resonated in the private sector very strongly. Not only were those interviewed willing and ready to answer questions about health insurance, they responded passionately about the subject. Several small employers deeply regretted not being able to offer or having to discontinue offering health insurance as a benefit to their employees. They saw first hand how this affected their workers and each one had a story about a certain employee without insurance who had to go to great lengths to deal with a health issue. One told of a false workers compensation claim made by an injured employee. The story was told in a non-accusatory manner, rather as an explanation of the lengths people went to and how it ended with a type of cost shifting by adding to employers' costs.

A clearer picture evolved around people who worked but did not receive insurance from their employer or those who are sole proprietors. People who are working, whether for themselves or for a small business owner, are either going without insurance or are paying a significant sum for what amounts to a catastrophic health care plan. In small businesses or non-profit organizations the situation of helping employees find health insurance was at a crisis point and frequently employers were not offering health insurance but rather asking employees to find a plan and then negotiate how much would be paid by their employer. All those interviewed from the private sector expressed considerable frustration about the whole issue and often about what they perceived as the legislators inability to "roll up their sleeves and get to work on the problem." This may indicate that they are unaware of the many incremental changes made to public insurance programs or that the changes were not perceived to be helpful.

Employers

Over and over employers stated that they want to offer health insurance as a benefit so they can recruit and retain good employees. The importance of being able to get health insurance was often a deciding factor about which jobs people take. One larger employer said that it is often the first question asked in an interview of a potential employee. Another interviewee mentioned that she had been told by some employees that they would work until they qualified for Medicare even if they wanted to retire earlier as getting an individual policy would be prohibitively expensive for the gap years between working and Medicare. She mentioned that this was especially true with older employees who may already have a health condition.

To some of the non-profit organizations interviewed, being able to offer good health insurance benefits to professional level staff was the defining reason that people could come to work for them rather than in the higher wage private sector. They all reported that they had to become more and more creative in being able to offer those benefits as they see the premiums rise at double-digit rates. One non-profit administrator saw incentives to lessen the burden of the cost of health insurance in the not-for-profit world being very possible through a form of payroll tax credits.

Employers' Perceptions of Medicaid & CHIP

When asked about the public insurance programs there were widely different views and knowledge base. There was some dissatisfaction expressed about the lack of options they have when compared to all the programs available for "poor" people, sometimes accompanied by a remark such as "I would never go on one of those programs," or " I would do anything I could to avoid asking for charity." It is interesting to note that among some, the problem of how to provide coverage to the "chronically uninsured" was not perceived as the biggest problem in the issue of lack of health insurance. Rather the most pressing problems lie in how to contain health care costs and how to bring younger, healthier people into the insurance pool to balance out the threat as the state's population ages and requires more health care.

There was some understanding of the Children's Health Insurance Program (CHIP) and some employers knew of an employee that utilized the program. There were no derogatory remarks about CHIP, one interviewee saying that as a society we have to take care of the children first. However, when Medicaid was mentioned, particularly when asked if they would support an expansion of Medicaid, the reaction was negative. Remarks indicated a lack of knowledge about the program, with some viewing it as a handout to those too lazy to work.

Incentives, Subsidies & Tax Credits

The question concerning how likely businesses would be influenced by subsidies, tax credits or other incentives was universally answered by those in private industry with a very qualified "maybe" with the observation that incentives would probably not be large enough or would not be useful to all businesses who needed them. For some owners of small businesses the question about being offered tax credits or subsidies would be very welcomed only if it didn't raise taxes in other areas.

Insurance Companies

The fact that private industry's access to health insurance is inextricably tied to insurance companies was well understood. Interviewees from the private sector understand that insurance companies are a business with a need to show profit but they also expressed frustration at what they perceive as a lack of affordable products for small businesses. However, both insurance companies/insurance agents and small businesses thought the solution was some type of universal, single payer system, although few had suggestions as to how to get to that type of program.

Some cynicism was expressed about the role of insurance companies in the health insurance problem. That they focused only on the bottom line or that those that work with farming and ranching families on other types of insurance deliberately did not mention their health insurance products as it would not make them money. The spiraling cost of health care and the continuous expansion of health care facilities were linked to and blamed for the crisis in health insurance. Several mentioned that health insurance has always been viewed as a benefit to employment and this presents a barrier to change. The very term "benefit" indicates we get something from having it and from an insurance perspective this attitude can no longer drive people's

expectations. The correlation between poor lifestyle choices and escalating health insurance costs was clearly understood among those representing the insurance industry. No immediate solution was laid out other than the situation would have to change and those people making healthy lifestyle choices should not be in the same pool as people making choices that adversely effect their health.

In fact, several employers voiced the opinion that insurance companies will not take the situation of escalating health care costs much longer. Also they will find a way to curb what is often perceived as over utilization of health care and will eventually offer health insurance with the same conditions with which they now offer car or homeowners insurance. In the future, even if it took regulatory or legislative changes, the high risk populations will be denied or dropped without recourse even to the very high cost plans.

Lack of Competition in the Montana Market

Lack of competition in the Montana insurance market is seen as a primary reason that more insurance products are not available. However, they understood that the small size of the state's market would never attract the competition among insurance companies that exists in larger markets. Another aspect of Montana's population size that was identified as effecting health insurance is the lack of any type of large Health Maintenance Organization or Preferred Provider Organization. Another comment on lack of competition pointed to the unregulated nature of competition and that companies are allowed to come into the state and offer good prices to healthy groups and can avoid having to cover the high risk, older pools.

Blue Cross and Blue Shield of Montana was identified by all who mentioned lack of competition in the health care market. Sometimes the comments were negative but mostly they reflected an understanding of the Montana health care market that precluded many national carriers being interested in coming into the state. One interviewee pointed out that even if Blue Cross keeps 20 cents out of every dollar for their overhead, that still leaves eighty cents locked into the cost of health care.

Farming and Ranching Community

People in the farming and ranching sector were specifically mentioned by more than half the interviewees as having unique problems around accessing health insurance. These problems were seen to be multi-faceted with the following identified:

- distance/access to providers;
- high assets disqualifying them from public insurance, even if their income qualified them;
- traditionally a community that looked after it's own and would not ask for help;
- perception that the public insurance programs were "charity";
- high premiums and high deductibles were not affordable;
- no ability to pool;
- having Workers Compensation confused with having private insurance; and
- mobility of seasonal farm workers prevented them from accessing county-based programs.

The issue of a "cultural divide" was often mentioned indicating a split between those who would never access public programs versus those who utilized all programs for which they are eligible. This discussion often included talk about how the unique pioneer spirit of Montana affects the health insurance debate with those from the rural areas being most likely to never seek help and to feel they should be able to pay their own way. Hence, as health care costs skyrocket, few families with this ethic can afford routine, preventative visits let alone a catastrophic health event.

Several observations specific to the farming and ranching community were made indicating their problems accessing and affording health insurance are unique and not likely to be solved without being specifically addressed. One is that many working land owners in Montana have high assets that could be targeted should a family without health insurance suffered a catastrophic health event. Their inability to pay high health care costs would result in losing their land and livelihood. This creates the situation that many farming families will pay almost anything just to have the catastrophic coverage to avoid this situation. Whether this is a reality or an assumed result of not having health insurance was not mentioned. It is interesting to note here that in interviews with different hospitals around the state, much emphasis was placed on figuring out ways to avoid high medical debts so that the hospitals would be able to collect on their bills and avoid taking legal action.

Not being able to afford or find an individual or family health insurance policy is a major reason that drives a farming or ranching family member off the farm and into the closest community to seek employment with health benefits. This point was emphasis strongly by several interviewees. The competition for such jobs in small rural towns and communities is very fierce and the jobs are thus not only difficult to find, they are difficult to get. Prime jobs are considered those with state agencies or with the local hospitals, others include those with public utilities or local school districts. This phenomenon is more and more the norm for farming families and one-way commutes of an hour and a half are not unusual.

An interesting aspect of the agricultural community concerned seasonal and migrant farm workers employed by farmers. For many reasons, mobility being primary, these workers seldom have any type of health insurance and are at the low end of the wage scale. By law they are considered contractual employees. If any dispute arises between employer and employee there is seldom any written, signed agreement as much business in the agricultural community is conducted verbally. This leaves the worker at a disadvantage in trying to settle any wage dispute and may contribute to a family's poverty, which contributes to them being unable to access health care.

The Montana Comprehensive Health Association (MCHA)

This plan, also referred to as Montana's high-risk pool, was mentioned in several interviews across all sectors; however, those in the private sector knew it best. It was considered a "last resort" because of the expense and the fact that an individual had to be denied by three other insurance plans before being eligible to apply. Interviewees

from the agricultural sector were the only ones that knew of "several" people who had to use it and it was suggested that the plan could be changed so that farmers and ranchers could access coverage without the required three denials. Some of the small business owners had looked into getting their own coverage through MCHA but had found slightly cheaper and more comprehensive plans from such companies as Fortis or other group plans. Without exception across all interviewees the MCHA was not considered a successful response to the problem of accessing health insurance and, by some, was identified as part of the problem.

IV. Government Sector

Those interviewed in the public sector primarily represented administrators of health care programs, at a county, municipal or statewide level. As was to be expected, these interviewees had the greatest understanding of how state or federally funded programs actually work. Those administrators of programs funded through the federal government were not as overwhelmed by threat of impending budget cuts. Whereas state administrators were still trying to assess the consequences and ramifications of cuts in the aftermath of a contentious legislative session.

Expansion of Public Programs

All interviewees in the public sector would welcome expansion of public insurance programs but no one realistically thought it was going to happen. The realities of tight fiscal times in Montana were all too well understood and the pressure that Medicaid puts on the state budget will only continue to grow. Expansion of both CHIP and Medicaid were thought to be necessary to provide coverage to those chronically uninsured. As stated below, there was a similar response from health care providers, both private practitioners and those who served low-income groups. Expansion of Medicaid would be a good investment as the state runs the Medicaid program at a 4 percent administration overhead versus Blue Cross/Blue Shield's overhead of 20 percent. However another idea was to provide Blue Cross/Blue Shield with some type of public subsidy to expand products such as MontanaCare.

Suggestions on CHIP expansion were to increase the income eligibility level to 200 percent of the federal poverty line, to change the federal regulations and allow parents of CHIP kids to pay a fee for service and in general to stabilize the program to eliminate the waiting lists.

Again those who worked for government programs agreed with health care providers on the necessity of providing some type of public insurance program for adult males. With the low wages earned by many Montanans, especially those who worked in the tourist/service industry, this group has no affordable access into the health care system.

Participation in Public Insurance Programs

When asked why some people do not participate in public insurance programs responses fell into two categories – people who were too proud to "accept charity" and those become overwhelmed by the process. For the later group, convenience of

the application and re-consideration process was a bigger problem than most people think. The distances to county offices in rural areas is a problem and some are crowded and unappealing especially to people with children. Although it was felt that the stigma of being on a public program was not such a big problem as it used to be, there remains one for some rural families. Even having to go into a county office is an embarrassment for some people.

The compartmentalization of public programs translates into a lack of coordination, which renders the process of access very hard especially for families in crisis. Some interviewees said that most departments are still on a steep learning curve to create a more seamless service delivery system with multiple points of entry.

Public Versus Private Perceptions

The disparities between the answers from those in the public sector and those in the private sector were most pronounced. Whereas people who work in the public sector have an understanding about these programs, who they serve and what they cover, there appeared to be a widely different understanding about the programs among those in the private sector. There was an underlying sense of unfairness expressed by some who have worked all their lives and who pay exorbitant amounts for their health care insurance and never thought of using public insurance programs when they perceive that some people "get something for nothing." Whereas administrators of public programs see the hardships imposed on families in poverty and they had much empathy with the struggles people have trying to make it through the maze of public insurance programs. This disconnect is not mentioned as a value judgment, rather it is an observation important to note because policy decisions and programmatic changes are made in the political context of competing interests. For Montana to truly address the problems associated with lack of health insurance, these disparate viewpoints have to be addressed.

V. Health Care Providers/Hospitals

Medical Professionals

It is of no great surprise that most health care providers (doctors, nurses, etc.) expressed great frustration with the current situation with health insurance. Doctors, psychiatric social workers and nurses were interviewed; all treated patients who used both public and/or private insurance as well as patients who had no insurance. Some of the interviewees also had administrative duties as well as treating patients, while some now were 100 percent administrators after having practiced as nurses or physicians.

A picture emerged of a confusing, uncoordinated system in which medical practitioners do the best they can for patients while being constrained by the rules and regulations of insurance programs, both public and private. An inordinate amount of time is spent just trying to figure out how to pay for treatment. The tension that exists between the medical community and the insurance industry was clearly expressed, as it also was in some of the interviews with people representing the insurance industry.

Children's Health Insurance Plan (CHIP)

CHIP was consistently praised and expansion of CHIP to cover all children on the waiting lists as well as covering parents of children through a CHIP-like program was identified most often as the best way to expand any of the public programs. Another recommendation on expanding CHIP was to raise the qualifying income level to 200 percent of the federal poverty level. However, it was clearly understood that expanding one program most often means cutting some other program causing hardship to other groups. The cut backs in case management for some of the programs for low-income people were also identified as a short-term cost cutting measure rather than a long-term cost saving measure.

Participation in Public Programs

There were several identifiable themes when these health care providers were asked why people do not participate in public insurance programs if they are eligible. The challenges and barriers to participation most often mentioned were the complexities of the programs, people forgetting to re-enroll, or the distances to county offices being too great in rural parts of the state for it to be worth it to a family. For patients at the bottom of the economic ladder, the co-pays are seen as too high for some and for others, with very low literacy levels or without the required documentation, the hassles to fill out applications were just not worth it when they know that they can go to the emergency room at the local hospital. Many public health centers working with this population have a full-time staff person just to deal with enrolling people in programs for which they are eligible, but it is often hard to keep track of individuals because of the mobility of the population. The health care providers in community health centers often pointed out the fact that there is no public insurance program for single males.

Other reasons for non-participation is that sometimes families will choose not to go onto a public program as it is viewed as charity and their strong work ethic and pride did not allow them to accept a "hand-out." Others were "kicked off" Medicaid for what the provider felt was an insubstantial reason. All providers recognized the continuous crisis that poverty or a catastrophic health event caused people and felt that it was not surprising that people did not participate or were dis-enrolled from public insurance programs.

Reimbursement Rates

From a health care perspective, all providers felt the public programs available fall short in allowing them to practice the best medicine. One practitioner stated she has to overbook just to get paid enough to maintain services and this does not give adequate time for each patient. Several physicians point out what it costs their practice to treat patients on Medicaid and they know their charges have to be higher just to make up for Medicaid's low reimbursement rates. These low reimbursement rates for Medicaid were identified as the major reason it is hard for Medicaid patients to find a doctor who will accept them, which, in some views, creates a demeaning system where people needing health care are forced to make multiple phone calls and "beg" to be seen. And once they found a doctor they were often unfairly stigmatized as Medicaid

patients being confined to appointments only on certain days "because those are the only days the doctor will you Medicaid patients."

Hospitals Administrators

In discussions with hospital administrators it became very clear how creative they have to be with programmatic and financial solutions for patients without health insurance. Hospitals are being forced to think of ways to avoid unpaid large medical bills. Innovative public/private partnerships exist in some communities with positive results for both provider and patient. However, it appears that in other communities people are unaware of these examples of potential best practices. The large hospitals are, of course, at the greatest advantage as they have more resources and extensive networks within their communities.

Again the issue of low reimbursement rates from public insurance programs, such as Medicaid and Medicare, were frequently mentioned as an area in which hospitals lose money. That is a fact of doing business about which they can do little, however, they can and are doing much to provide service to the uninsured. One hospital holds a large six-figure dollar amount in payment agreements with people in the local community. They do not charge interest and are in effect a loaning institution for people who cannot get underwriting from a local bank.

An interesting counter point was made to the charge that hospitals are getting rich and building brick and mortar palaces. This was identified as a "huge misconception" that indicated people did not understand how much hospitals lose in bad debt or because of low reimbursement rates.

The interviewed hospitals administrators were widely and well informed about all aspects of problems associated with health insurance. They had in-depth knowledge of both private and public programs and an understanding of what drives health care markets.

VI. Advocacy & Direct Service Community Groups

Interviewees from this sector covered a broad range both geographically and programmatically and were all from non-profit organizations. Some served specific populations and others were membership based advocacy groups. All discussed the issues around health insurance from both a consumer and a provider/membership-based perspective. Poverty was the prevailing theme amongst interviewees in this sector. They specifically discussed poverty bought about by low wages and lack of benefits for those who are working and by structural inequalities in allocation of resources for those who relied on public programs for subsistence.

Health Insurance Offered by Non-Profits

Dealing with the spiraling costs of providing health insurance as a benefit has severely impacted non-profits in the state. Traditionally offering good benefits was a value-based decision of non-profit management when often wages were not commensurate with those in the private sector, however, some questioned that small

non-profits could afford to continue. One non-profit administrator pointed to the recent study done by the nascent Montana Non-profit Association where a survey of non-profits identified health insurance costs as a major problem. As individuals working for non-profits, the interviewees expressed worry for themselves and their families and one person admitted avoiding going to the doctor because of cost.

Impact of Health Insurance Problems on Disadvantaged Groups

Many of those interviewed represented groups that traditionally do not have access to health insurance and they all had heartbreaking stories about experiences of individual trying to get medical care for themselves of their families. The fact that welfare reform in Montana has forced many off Medicaid and into jobs without benefits was seen as "penny wise and pound foolish." These individuals are joining others in the "working poor" category and are seen as the ultimate victims of a broken health care system. If a family experienced a serious health care problem, they could get into a viscous downward cycle of debt and bad credit.

Accessing Public Insurance Programs

Interviewees agreed with many of the comments made by administrators of government run insurance programs, but stated them much more forcefully pointing to the loss of privacy and stigmatization of families on Medicaid. The application process for CHIP, however, was considered much more user friendly and all interviewees praised this program.

Advocacy Groups & Providers' Perception of Hospitals

There was definitely a disparity of responses from many in this group and from those in the health care provider/hospital sector. Lack of compassion from hospitals for low-income people trying to pay their medical debts was mentioned by two advocacy groups, whereas those interviewed from hospitals highlighted their programs and attempts to help people with their bills. The lack of information for low-income health care users about hospital charity plans was also identified as a problem.

Advocacy Groups & Providers' Perception of Insurance Industry

The insurance industry was identified as another source of problems associated with health insurance. Their lack of consideration of the unique set of circumstances faced by certain families, their preoccupation with the bottom line, their restrictive policies, their lack of engagement in trying to solve the crisis were all mentioned in relationship to the role of the insurance industry in the uninsured problems.

Minority Specific Concerns

Four people interviewed worked for organizations that served minority populations or were membership based organizations representing minority populations. A far-reaching problem for American Indians who live in urban areas, after living off the reservation for six months, lose access to health care through Indian Health Services. According to two interviewees many Indians do not know this and are unprepared when they have a need for medical services and have no insurance and often few resources to pay for treatment. It was reported that the Indian Health Centers were not

enough to serve all the needs. For one of the agencies interviewed that served Indian children all of whom qualified for Medicaid, said that they have to obtain a new Medicaid card every month for every child which is burdensome and detracts from providing services. The reductions in the reimbursement rates have forced them to drastically cut services.

Another minority with specific health care needs but which seldom has access to health insurance are Montana's seasonal and migrant farm workers. The inherent nature of the work requires mobility that precludes them from accessing county-based services such as CHIP or Medicaid. The long determination period for Medicaid renders this program almost useless for farm workers. Also this population experiences many serious long-term illness because of poverty and the hard physical labor required by their work. There are many cultural and linguistic barriers to accessing health care for this mostly Hispanic group.

VII. Mental & Dental Health Coverage

The issues around health insurance providing coverage for mental health and dental services are given a separate section in this report because of their magnitude. They were mentioned by 100 percent of all people interviewed. The fact that they have traditionally been viewed as distinctively separate parts of health care as a whole was identified as the initial problem although people did not see this changing despite the national debate on mental health parity. Lack of meeting oral and mental health care needs was identified as a major problem facing people without adequate health insurance. These problems, although preventable and treatable at a relatively low-cost, can escalate into high cost health care issues.

Results of Non-Treatment

The strongest opinions on the subject of mental and dental health came from health care providers. They daily see the results of people not getting adequate treatment at the initial stages of emotional, mental or dental problems and have to often treat people with highly expensive modalities for conditions that could have been treated at much lower expense. This was particularly true for young adults who had never been to see a dentist as children and who ended up in the emergency room for acute teeth problems. One provider at a local community health center told of seeing 17 and 18 year olds who have to have all their teeth extracted. Likewise, another provider pointed out that if a person starts taking a low cost drug for something like depression their insurance premium goes up 20 percent. However if left untreated the condition could result in high cost treatments.

Inclusion in "Bare-Bones" Health Plan

When asked what constitutes a "bare bones" health insurance policy the overwhelming number of responses included mental health and dental coverage. However, the amount people should pay and extent of the coverage fell on a continuum. Those who daily serve people from low-income communities who are on Medicaid had the strongest opinions about the lack of mental health benefits and a sense of outrage about what so many people had gone through while with the state

contracted out the Mental Health Access Plan to a managed care company and now with further limits to services and increases in co-pays. The amount of time that it takes the state mental health system to determine eligibility was mentioned as a barrier to participation as by the time the determination is made the provider may no longer be able to find the patient to initiate services. The delay can mean the difference between getting the patient needed services and potentially deflecting a crisis or not getting services with the patient ending up in high-cost hospitalization or in the justice system.

Psychotropic Drugs

Many health care providers talked about the issue of psychotropic drugs and the problem of finding ways to ensure that those with serious mental illness could get what they needed. The difference between the side effects from the generic versus the brand name drugs was often mentioned with much frustration as, understandably, patients choose not to put up with side effects of the old drugs even if these are the only ones they can afford or that are covered by their insurance. To ensure that their patients could get the drugs they needed, one community health center did all the paperwork to access the charity drug programs runs by the pharmaceutical companies. They had made over seven hundred referrals to such programs with great results for the patient; however, they readily admitted that the drug company programs are cumbersome and almost indecipherable to a patient in a mental health crisis.

Another different, but important, aspect of Medicaid coverage for mental health was reported by one physician. Children are being prescribed psychotropic drugs for behavior control instead of receiving less invasive and often more effective treatment modalities because of what services Medicaid will or will not cover.

VIII. Other Comments of Note

Following are some other comments not included in the above narrative mentioned by interviewees:

- The recent emphasis by the Bush administration on expanding funding for Federal Qualified Community Health Centers was positively received, as these types of health centers are a good solution to providing health care to under- or uninsured people.
- Loss of the safety net for very low income people due to recent state cut backs has become a real problem.
- For economic reasons young people between 18 and 25 years of aga often decline health insurance if they are offered it as a benefit.
- Young adults tend to think of themselves as invincible so do not think about having health insurance and yet when they have an accident or injury it is often severe and extremely costly.
- Health insurance policies should cover preventative and maintenance health care but they often don't because of the upfront cost. This is viewed as the insurance companies being a business and having to look at the bottom line in offering their products.

- Both federal and state laws and regulations often prohibit insurance companies from offering innovative plans.
- People sometimes do not see benefit in health insurance if they are not utilizing it and will often drop coverage.
- More middle-income families are going without health insurance and they have no experience with public programs.
- Expansion of health insurance programs should come through the private sector; people would much rather have it through their employer than accept it as charity from the government.
- There is a need to strengthen Montana's economic base so that businesses can once again offer affordable health insurance benefits.
- All sectors need to explore forming groups so that health insurance will be more affordable to more people.
- Small communities rally around their own. When someone in the community has a health crisis and is unable to pay, communities hold fundraiser but are never able to raise enough money. Local businesses may rely on the good nature of the community instead of offering health insurance.
- There was a concern that the Community Health Center would take money away from local health care facilities of medical practices.
- People are "underinsured" when they have to decide between visiting a doctor and buying food.
- We need to go beyond the medical model that more and more health care will solve the problem, everything can not be cured by a pill. Our lifestyle choices are key.
- The answer to having national health insurance is more Community Health Centers.
- Insurance companies are not making an honest effort to solve the problem, some may be trying but I don't see it.
- Insurance companies need to protect their investment; when they pay for hospitalization they should also pay for aftercare.
- Legislators in Montana seem to think that we are still a resource based economy.
- Party politics, control issues and lack of ability to compromise are stopping any solutions from being created. Both parties are to blame for that. Our future lies in their hands and they are busy posturing.
- Government should place limits on what insurance companies can charge and what they can withhold in terms of benefits.
- We must work to be able to maintain people's health over time instead of waiting for high cost treatments or chronic illnesses.
- If you are on the Passport Program you can only go to your primary care provider, but you may have a specialized need that requires a different doctor. You have to jump through incredible hoops to see a specialist.
- Medicaid eligibility should take expenses into consideration not just income. Some families have unique, unusual higher expenses.
- It is a travesty that no state money is put into the Community Health Centers.
- Often people will not go back to a health care facility to which they know they owe money, so they do not get needed treatment.

- Some hospitals around the state are much more aggressive about their collection policies.
- Sometimes people on Medicaid who are temporarily working have their wages arbitrarily annualized and they are consequently dis-enrolled from the program. It takes forever to straighten out the problem and get them back on Medicaid.
- Some people have to fall back on the Community Health Centers. They are not "insurance" but in effect they are a government-subsidized service.
- If the country goes to a universal, single payer system for providing health care, corporations might welcome it as it will take the headache of health insurance off their plate.
- Just like this country made a choice about education – health care should be universally mandated.
- Sometimes we see people who have no insurance and they hope that they may be descendants so they can access Indian Health Services.
- The upfront costs of changing the way people access health care would be daunting, but it would cost less down the road.
- All seniors have a health insurance program through Medicare, why not a program like that for children?
- Montana has an exciting opportunity as it could do something absolutely new and innovative instead of just tinkering with the old system.
- We need to acknowledge that in being aggressive about welfare reform we have dumped a lot of people into the uninsured pool.
- If we offer preventative services, we can say there is a tremendous pay back, but we have to realize that it is all about up front costs.
- The solutions will be driven by the economy and we need to help see people see this complexity.
- Even if we pooled all the people in Montana, our rates would keep going up in relationship to medical trends.
- Having a Medical Savings Account (MSA) is the only way we have survived our high insurance costs. MSA's should be part of the solution for the health insurance crisis.

Appendix A

Key Informant Interviews

METHODS
Informants
Key informants are individuals selected for their first-hand knowledge about a particular group of people. They work closely with a specific population and therefore possess special understanding and access to the perceptions of that population, and the systems within which the population interacts. For this study individuals who work with Montana's uninsured population, and those at risk for becoming uninsured, will be chosen from the following four categories:

- Health care providers (physicians, nurse practitioners, physician assistants, caseworkers, social workers)
- Private Industry (human resource directors, owners, insurance agents)
- Administrators (of clinics, doctors' offices, hospitals, insurance companies)
- Community leaders, advocates, elected officials and union representatives

Health care providers (physicians, nurse practitioners, physician assistants)

1. Drawing on your view from a rural standpoint, why don't people have health insurance?

2. Why don't people participate in public insurance if it's available?

3. Why do some people dis-enroll from public insurance programs?

4. What is your experience, from businesses standpoint, with public insurance programs?

5. What is your experience from a health care perspective?

6. If there was a way to expand public insurance programs, would that affect you?

7. How would you define "underinsured?"

8. What constitutes the right insurance plan?

9. What program would work to cure the problem of the chronically uninsured?

10. Would your organization be interested in expansion of programs?

11. What would be your words of wisdom to legislators?

12. Final Comments?

Private Industry (human resource directors, owners)

1. Let's start by telling us a little bit about your health insurance program at [your company], its mission and goals, number of employees covered, etc.

2. Many businesses don't offer health insurance to their employees. What influenced your decision to offer insurance to your employees?

3. What are the issues/problems you have had to grapple with in order to provide insurance to your employees?

4. How do you decide what health insurance benefits to offer? How do you decide what level of premium employees should pay?

5. In your opinion, what would you call a minimally acceptable benefit package?

6. How likely are businesses to be influenced by subsidies, tax credits, or any other incentives that would lessen their share of the cost of heath insurance?

7. What words of wisdom do you have for legislators and other government officials who might attempt to craft a public insurance program for the chronically uninsured?

Administrators (of clinics, doctors' offices, hospitals, insurance companies)

1. What factors prevent people from purchasing health insurance? Why are some people not insured today?

2. Why do some people not participate in public insurance programs?

3. Do you support expanded public insurance programs?

4. How do you define underinsured?

5. What constitutes a minimum "bare bones" health insurance policy?

6. How can we best provide coverage to those chronically uninsured?

7. Could you comment on the strengths and weaknesses of expanding some of the current public insurance programs?

8. What advice would you give the legislators as they try to close the health insurance gap in Montana?

9. Would you like to make any other comments?

10. Could incentives such as tax breaks, etc. help employers afford health insurance?

11. Could you comment on “crowd out?”

Community leaders, advocates, elected officials and union representatives

1. In your opinion, why don’t some people have health insurance?

2. What role do businesses play in the uninsured problem?

3. What role do you see the government playing in the uninsured problem?

4. What role do you see the insurance industry playing in the uninsured problem?

5. What role do the people play in the uninsured problem?

6. What about gaps in health insurance?

7. In your opinion, what constitutes a minimum benefit package?

8. In your opinion, what should public health insurance include?

9. Would an economic downturn affect what you provide?

10. What advice do you have for the government about closing the health insurance gap?

11. Do you have any other closing thoughts?

Appendix B

INFORMED CONSENT FORM FOR KEY INFORMANT INTERVIEW

Study Title: Health Insurance in Montana
Sponsor:
Montana Department of Public Health & Human Services
Investigators:
Bureau of Business and Economic Research (BBER), The University of Montana-Missoula

Address: The University of Montana, 32 Campus Drive #6840, Missoula, MT 59812-6840

WHAT IS THIS STUDY ABOUT? This key informant interview is part of a project that is surveying households across the state to see how well people are accessing health insurance. The project is also contacting businesses to gather information on some of the issues Montana businesses face when offering health insurance to employees. Your participation in this group will contribute to more accurate information on health insurance and will provide important input to a state project overseen by the Department of Public Health and Human Services.

WHO MAY PARTICIPATE? You must be at least 18 years of age to participate in this study. No questions will be asked without your consent or before this consent form is signed.

HOW LONG IS THE INTERVIEW? The interview lasts about 60-75 minutes.

WHAT ARE THE POSSIBLE RISKS? The information collected is about major issues and concerns about health insurance and access to health care. You may withdraw from the study at any time. Again, all information will be kept strictly confidential.

WHO WILL HAVE ACCESS TO MY ANSWERS? As a matter of state and federal law the sponsors and investigators are required to protect the privacy of everyone who participates in this survey. Only the surveyor will know the identity of individuals participating in this study.

1. You may skip any question you do not wish to answer.
2. The investigators will summarize all the survey responses. No individual responses or information that could be used to identify any individual will ever be released.

WHAT BENEFITS WILL I RECEIVE? You will be contributing to a better understanding of health insurance and health care access problems in the state and will be contributing to public policy on health care access.

WHO MAY I CONTACT IF I HAVE QUESTIONS? For answers to questions about research and research participant's rights, please contact Dr. Steve Seninger, BBER Director of Economic Analysis, at (406) 243-5113.

AUTHORIZATION: This research project has been explained to me by the interviewer and in this consent form. I voluntarily execute this consent form as my own free act and deed, and am willingly and freely consenting to participate in this study. All of my questions have been answered to my satisfaction. I will receive a copy of this consent form to keep.

_____
Interviewer

_____
Participant

_____Date